Daniel M. Finley
County Executive

Cathy A. Bellovary
Director

Waukesha
COUNTY

DEPARTMENT OF
SENIOR SERVICES

ELIGIBILITY APPLICATION
for the
Taxi, RideLine, &/or ADA Specialized Transportation Programs

*** The Taxi Program:**

For Waukesha County residents, who are non-drivers, age 65 years or older, and able to enter or exit an automobile with little or no assistance.

AND Waukesha County residents, who are non-drivers, 18-64 years of age, able to enter or exit an automobile with little or no assistance **and** receive either SSI or SSDI. A Benefits Verification Form can be obtained from:

Social Security Office
707 N Grand Avenue
Waukesha WI 53186
Telephone: 1-800-772-1213

*** The RideLine Program:**

For Waukesha County residents, who are non-drivers, age 65 or older, **unable** to enter or exit an automobile, and require an accessible vehicle, **or** have no taxi service in their community, **or** need to travel outside of taxi service area.

AND for those Waukesha County residents, who are non-drivers, 18-64 or older, **unable** to enter or exit an automobile, use either wheelchair, scooter, cane, walker, crutches, or are legally blind.

***Service to adjoining Counties *ONLY* for second opinions, consultations, or services *NOT* duplicated in Waukesha County.**

*** The ADA Paratransit Program:**

For individuals with disabilities, who meet **ADA** certification eligibility and cannot use a regular *mass transit* fixed route system due to their disability. (*This service is only provided in a narrow corridor along I-94, from the city of Waukesha to Lake Michigan – with a temporary extension to UW-M, when it is in session, as well as a Brookfield – New Berlin Corridor)*

Send your completed application with the:

- **RideLine Fare Determination Form (Choose OPTION A or B)**
- **SECTION A (completed by you)**
- **SECTION B (completed by a health professional)**

TO: Waukesha County Department of Senior Services
1320 Pewaukee Road Room #130
Waukesha, WI 53188

OR FAX TO: (262) 896-8273

Waukesha County Department of Senior Services

RIDELINE FARE DETERMINATION FORM

Name _____ **Birth Date** _____

Address _____ **Apt #**_____ **Zip** _____

City _____ **Phone #**_____

What is your Title 19 number? _____

If you receive T-19 or COP (Community Option Program) do not complete the remainder of this page.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Choose OPTION A or OPTION B **IF** you do not receive T-19 or COP

OPTION A: I do not wish to divulge my financial information. I agree to pay the following Fare **Structure**:

One-way trip within the same community - $7.25
One-way trip from one community to another - $9.75
One-way trip to an adjoining county (available ONLY for medical and ONLY if service is NOT available in Waukesha County) - $16.25

*Signature*_____*Date*_____

OPTION B: I have listed my financial information for the Department of Senior Services. The information will be used to determine my RideLine fares based upon my ability to pay and the 2002 Fare Structure.

	Passenger	*Spouse*
1) Average Monthly Income:	$_____	$_____
2) Total Liquid Assets:	$_____	$_____
3) Average Monthly Medical Expenses:	$_____	$_____

1) Average Monthly Income: include your social security, pension, disability, wages, interest/dividends, rental income, and any other income you may receive.

2) Total Liquid Assets: include savings & checking accounts, investments (CD, stocks, bonds).

3) Average Monthly Medical Expenses:
Include medicine, medical supplies, health insurance premiums, and dental, doctor, or hospital bills. **DO NOT INCLUDE** medical expenses paid for by Medicare, Medicaid, or other insurance.

This information is true and complete to the best of my knowledge. I authorize the use of this information by representatives of the Waukesha County Department of Senior Services for the purposes of verification. I understand this information will remain confidential.

*Signature*_____*Date*_____

Please Return to: Waukesha County Department of Senior Services
1320 Pewaukee Rd Room 130
Waukesha, WI 53188

Or Fax to: (262) 896-8273

ELIGILIBILITY APPLICATION
Waukesha County Department of Senior Services Specialized Transportation Services
Taxi Program – RideLine Program – ADA Paratransit Program

SECTION A: ***APPLICANT MUST ANSWER ALL QUESTIONS ON BOTH SIDES OF THIS SHEET***
Information provided on this application will be confidential and used by Waukesha County Department of Senior Services for determining eligibility for the specialized transportation service **most appropriate for your needs**. If you need assistance completing this application, call the Department of Senior Services at (262) 548-7848.

PLEASE PRINT

1) Name_____

Mailing Address_____Apt #_____

Street Address (if different)_____Do you live alone?_____

City_____ State_____ Zip_____

Home Phone # _____ Work Phone # _____

Date of Birth _____ Current Age_____

2) Social Security Number_____

3) Medicare Number_____ and/or Title 19 Number_____

4) Do you drive?____ Yes ____ No Do you own a vehicle? ____ Yes ____No

Do you have regular use of an automobile? ____ Yes ____ No

Do you have any driving restrictions? ____ Yes ____ No If yes, explain_____

_____

5) Are you able to get in and out of an automobile with little or no assistance? ____ Yes ____ No

6) Can you independently board a standard urban transit bus NOT wheelchair-life or ramp equipped?

____ Yes ____ No Can you climb 3 steps, each 12 inches in height? ____ Yes ____ No

7) What is the disability which prevents you from using regular fixed route transportation?

_____

8) Do you have a health concern (e.g., diabetes, pacemaker) which the transportation provider should know? ____ Yes ____ No If yes, explain _____

9) Is your disability or limitation temporary? ____ Yes ____ No If yes, how long do you expect it to Last? _____ Is your disability due to a work related injury? ____Yes ____ No

10) If someone other than you will sometimes arrange your trips, give his/her name and phone number:

Name _____ Phone Number _____

11) Give the name and phone number of someone to be contacted in case of an emergency.

Name _____

Phone Number _____ Relationship to applicant _____

12) Do you use any of the following aids? ____ Yes ____ No If yes, **CHECK ALL THAT APPLY**.

____ Cane ____ White Cane ____ Orthotic/Prosthetic Device Guide Animal ____

____ Crutches ____Walker ____Portable Oxygen

____ Wheelchair ____Manual ____ Powered **Oversized?** Length _____ Width _____

____ Scooter **Oversized?** Length _____ Width _____

- If you use a wheelchair, your origin and destination must have a ramp or lift – If there is no ramp, you must have someone available to assist you up and down steps. **VAN DRIVERS ARE NOT PERMITTED TO TAKE ANYONE IN A WHEELCHAIR UP AND DOWN STEPS.**

*****You CANNOT ride on a scooter in the van – you MUST must be able to transfer to a van seat or a wheelchair.

13) Do you require an aide when you travel? ____ Yes ____ No
(For the purpose of this application, an aide is someone necessary for a person needing more than minimal assistance by the driver. You are responsible for providing a personal care attendant or aide).

14) If you use a wheelchair, are you able to transfer to another seat without help?
____ Yes ____ No

15) Do you have a ramp? ____ Yes ____ No
How many steps are there to maneuver when using the ramp? _____

*** SIGNATURE NEEDED***

I believe the information provided is true and correct. I understand that deliberately providing false information is punishable by law and may jeopardize the receipt of services. I hereby authorize Waukesha County Department of Senior Services to verify the information in this application.

** _____ _____

Signature **Date**

If you are completeing this application for someone other than yourself, you must provide the following information (please print):

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number: ( )_____ Relationship to applicant _____

I certify to the best of my knowledge the information given is correct.

_____ _____

Signature of person completing form for Applicant **Date**

MAKE SURE OF THE FOLLOWING BEFORE MAILING TO DEPARTMENT OF SENIOR SERVICES:

- **Section B (pages 3 & 4) of this application must be completed by a physician, nurse, Therapist, home health aide, or social worker.**
- ***The ENTIRE application should then be returned to the Department of Senior Services.***

Questions? Call Department of Senior Services (262) 548-7848 – TTY number: (262) 548-7948

Waukesha County Department of Senior Services
SPECIALIZED TRANSPORTATION SERVICES
The Taxi Program, The RideLine Program, & The ADA Paratransit Program

SECTION B: ***TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL:***
(physician, nurse, therapist, home health aide, social worker)

The Applicant has completed **SECTION A** of this application for specialized transportation services. In order for this application to be processed, **SECTION B**, medical certification of his/her disability is required. The Waukesha County Department of Senior Services will make the final determination as to whether the individual is eligible for the county's specialized transportation services and which service most appropriately meets his/her needs.

Applicant's Name_____ **Birth date**_____

Physician's Name_____ **Medical Office Name**_____

Medical Office Address_____

Medical Office Phone Number: ( )_____

1) Does the Applicant have any driving restrictions? ____Yes ____No If Yes, explain: _____
_____

2) Is the Applicant able to get in and out of an automobile with little or no assistance? ___Yes ___No

3) In your opinion, is the Applicant able to independently board a standard urban transit bus which is NOT wheelchair-lift or ramp equipped? ____Always ____Sometimes ____Never

Can the Applicant climb 3 steps – each 12 inches in height? ____Yes ____No

4) In your opinion, is the Applicant able to make transportation requests independently?
____Yes ____No

5) In your opinion, is the Applicant able to remember transportation appointments made in advance?
____Yes ____No

6) Is the Applicant's disability or limitation temporary? ____Yes ____No If yes, how long do you expect it to last? _____ Is the Applicants disability due to a work related injury?
____Yes ____No

7) Does Applicant use any of the following aids? ____Yes ____No

If yes, **CHECK ALL THAT APPLY.**
____Cane ____White Cane ____Orthotic/Prosthetic Device
____Crutches ____Walker ____Portable Oxygen ____Guide Animal
____Wheelchair ____Manual ____Powered ____**Oversized?**
____Scooter ____**Oversized?**

8) If the Applicant uses a wheelchair or scooter, is he/she able to transfer to another seat without help? ____Yes ____No

9) Does the Applicant require a personal care attendant or aide when traveling? ____Yes ____No
(For the purpose of this application, a personal care attendant or aide is necessary for persons needing more than minimal assistance by the driver. The applicant is responsible for providing a personal care attendant or aide.)

10) Are there any special considerations/accommodations necessary to transport the Applicant?
_____

11) What disabilities or limitations PREVENT this individual from independent mobility and the use of mass transit? **CHECK THE DEFINITIONS WHICH APPLY.**

____ **Non-ambulatory:** requires permanent use of wheelchair
____ **Restricted Mobility:** condition causes difficulty walking, requires use of mobility aid
____ **Arthritis:** causes a functional motor defect in any two major limbs
____ **Amputation of:** LEG: ____right ____left ARM: ____right ____left
____ **Respiratory Impairment:** occurs when climbing steps or walking
____ **Cardiac Disease:** results in marked limitation of physical activity
____ **Dialysis:** requires us of kidney dialysis machine & causes post-treatment weakness
____ **Chemotherapy/Radiation:** causes post-treatment weakness
____ **Spinal Disorders:** causes motor & sensory loss, osteoporosis with pain, limit of movement
____ **Nerve Root Compression Syndrome:** causes pain and motion limitation in back or neck
____ **Motor Impairment:** causes faulty coordination/palsy from brain, spinal, peripheral nerve injury
____ **Visual Impairment:** interferes with independent mobility
____ **Hearing Impairment:** interferes with independent mobility
____ **Developmental Disabilities:** interferes with independent mobility
____ **Autism:** interferes with independent mobility
Neurological Impairment caused by:
____ cerebral palsy ____ muscular dystrophy ____ Parkinson's Disease
____ multiple sclerosis ____ severe seizure disorder
____ neurological impairments not controlled by medication
____ **Mental or Emotional Impairment:** prevents independent mobility
____ **Aging:** limits mobility due to advanced age with fatigue & decreased energy level, restricted mobility & slowed response time, chronic & acute brain syndrome

12) Does the Applicant have a health concern (e.g., diabetes, pacemaker) which transportation provider should be aware: ____ Yes ____ No If yes, explain_____

I believe the information provided is true and correct. I understand that deliberately providing false information may jeopardize the receipt of services for the Applicant. I hereby authorize Waukesha County Department of Senior to verify the information provided in this application.

_____ _____
Signature Title Date

Thank you for your assistance. Please return this application to:

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